MDR Tracking Number: M5-04-2270-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on March 23, 2004.

Based on correspondence received from the requestor, ___, dated 06-29-04, the requestor has withdrawn date of service 08-25-03 for CPT Code 99080 from their dispute.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the 99090-analy clinic data, 99362-medical conference by physician, 99212, 99213, 99215-OV, 97530-therapeutic activities, 97265-joint mobilization, 97122, 97140-traction manual, 98941-CMT (3-4 regions), 98940-CMT spinal (1-2 regions) and 97012-mechanical traction, were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 04-30-03 to 10-16-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of July 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 6, 2004

MDR Tracking #: M5-04-2270-01 AMENDED DECISION
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a reviewer (who is board certified in) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant allegedly received injury to the low back region with radicular left leg pain while performing occupational duties, on ___. The said injury, resultant of a failed attempt to lift a heavy board, causing the claimant to loose his footing, progressively slipping and falling (conflicting description of injury in reviewed records, i.e. claimant lost footing and jerked low back region, but did not fall to ground) resultant of low back region as final destination of injury on set. The claimant reported the incident caused immediate pain and radiation down the left lower extremity.

On 3/21/03, the claimant sought immediate chiropractic care with ___ who performed x-rays on 3/22/03 revealing mild osteoporosis and degenerative disc disease in the lower lumbar region for this 73 year old claimant.

MRI of the lumbar spine performed on 3/22/03 revealed 3mm symmetric annular disc bulges at L4-L5 and L5-S1 with decreased widths by 70% and mild facet arthrosis.

NCV/EMG study performed on 3/25/03 by ___ found bilateral lower extremity somatosensory evoked potentials show delay in responses from the right leg region, evoked potential evidenced of right lumbosacral radiculopathy and possible superficial peroneal motor neuropathy.

RME performed on or about 7/10/03 by ___ who recommended passive type therapy for 3 weeks; however, before the completion of week 3, an active rehab program was initiated.

The IME performed by designated doctor, ___ on 9/09/03 found claimant to be at MMI on or about 9/9/03 with an IR of 5%and a final diagnosis as disc bulges at L4-L5 and L5-S1 with residual left SI joint dyskinesia.

Re-exam by ___ on 8/25/03 revealed increased flexion range of motion (ROM) from 60-80% with little to no pain, straight leg raise (SLR) increase bilaterally, also with very little pain.

The claimant returned to work (RTW) on or about 9/11/03 with referral for a pain management. ___ proceeded with continued care, instructions on a home exercise program (HEP) and a detailed explanation on disputed MMI.

Finally, ___ reported the claimant as RTW, with improved functional ability by more than 100% and decreased pain levels from an initial 8 to 0 on VAS pain scale. Assumedly, the claimant is now seen on an as needed (PRN) basis.

Requested Service(s)

The medical necessity of the outpatient services to include; 99090-analy clinic data; 99362-medical conference by physician; 99212, 99213, 99215-OV; 97530-therapuetic exercise; 97530-therapuetic activities; 97265-joint mobilization; 97122, 97140-traction manual; 98941-CMT (3-4 regions); 98940-CMT spinal (1-2 regions); 97012-mechanical traction, for DOS from 4/30/03 through 10/16/03 for the above mentioned claimant including E/M code 99090 on 4/30/03 and 99362 on 5/18/03.

Decision

I agree with the insurance carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

Purely, from documentation review alone, the available treating doctor SOAP notes do not meet the necessary requirements for proper documentation review to support continued treatment. To assist the treating doctor, I will list these one-by-one for his/hers future consideration with rationale.

- Pain levels on the visual analog scale (VAS) are not within levels that realistically require clinically supervised therapy, especially at the frequency reported (3 times per week). One would expect a claimant of this age to have minor aches and pains, as general life occurrences, especially if the claimant has remained (for several years) at the same type of job function/description.
- Subjective complaints remained relatively stable demonstrating no real change in response symptomatology, throughout this timeframe (4/30/03 through 10/16/03), as verified by the treating doctor notes.
- Objective evidence in this case was not overwhelming, to a point that would justify a continued treatment protocol for this lengthy timeframe.
- General statements such as "the claimant has shown increased ROM; decreased pain and decreased spasms," is not objective quantifiable evidence that progressive benefit is being accomplished. ROM needs to be in measured degrees and manual strength testing should be documented. Objective findings should be coinciding with subjective responses.

Note: Reviewing exam update on 8/25/03, reporting very minimal ROM deficits, if that. Definitely not enough to support the continued therapy that basis itself on increased ROM. One would expect a claimant in this age group to have some naturally occurring deficits, due to the aging process alone and these are probably normal values. Final analysis: This is not a good guide to base continued treatment support. Deconditioning, can also be expected, as a normal pre-injury occurrence and while it is very encouraging that the claimant demonstrated some improvement, with the exercise program, I fail to see how this was limiting the claimant from RTW and that it was a necessary part of treatment for this injury (i.e. there was mention to the fact of an FCE, however, none was available for this review).

Also, while I agree that this type of therapy can be relieving and feel good to the claimant, it was in no way reporting significant improvement gain (mainly because, it was already at a 1-3 level).

Generally speaking, treatment within the scope of MMI, needs to be progressive. Treatment beyond MMI, is more for its relieving qualities, per TWCC Spine and Extremity Treatment Guidelines,* used as a reference. Basically, the bottom line question here is; **did the claimant receive an adequate amount of treatment for the described injury up through 4/30/03?**

Based on the preceding rationale, it is my opinion that, the claimant did receive an adequate amount of treatment, up through 6/14/03, given age and delayed recuperative time. I don't consider that these levels (1-3 VAS), were debilitating, per documentation reviewed and thus, could reasonably be managed through self administered pain relieving techniques, following the 8-12 week initial course of chiropractic conservative care. Subsequent exam findings on 8/25/03, do not demonstrate the need for or the support of continued treatment, period. I do find it hard to ascertain, that the treating doctor is recommending the claimant to see a pain management specialist with 1-3 pain levels and at the same time, reporting that the therapy is making improvements.

Concerning code 99098; documentation did not reveal the reason for this charge on same day as office visit charge, while this charge is reserved for analysis, it is the doctors responsibility to be clear and concise about what particularly was necessary to analyze about this claimant that was extraordinary to this diagnosis.

Concerning team conference code 99362; this is generally reserved for multi-disciplinary specialized programs (i.e. work hardening), where multiple groups need to interact on different areas of concern. Documentation does not support this change.

The appropriateness for an 8-12 week conservative care treatment timeframe is supported by age and delayed recovery periods. However, there is very little here to support a necessity of clinically supervised treatment beyond this point, based on the preceding rationale and based on physicians, other than the treating doctor, who actually examined the claimant, reporting MMI considerations on 2 separate occasions.

* Even though the TWCC Spine & Extremity Treatment Guideline has been abolished, it still remains a reliable reference source to provide guidance, regarding the necessity of treatment.